

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/26/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155506		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 04/20/2011	
NAME OF PROVIDER OR SUPPLIER SANCTUARY AT HOLY CROSS--INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR SOUTH BEND, IN 46635			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for Post Survey Revisit (PSR) to the Investigation of Complaint IN00086091 completed on February 15, 2011.</p> <p>Complaint IN00086091-Corrected.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00088016.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the PSR completed on 2/15/11 to the Recertification and State Licensure survey completed on 1/12/11.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the investigation of complaint IN00087550 completed on 3/15/11.</p> <p>Survey dates: April 17, 18, 19, and 20, 2011</p> <p>Facility number: 001201 Provider number: 155506 Aim number: 100380860</p> <p>Surveyors: Antoinette Krakowski, RN, TC Vicki Manuwal, RN Mary Anne Cilella, RN (April 19 and 20, 2011)</p> <p>Census bed type: SNF/NF: 104 Total: 104</p> <p>Census payor type: Medicare: 34 Medicaid: 56 Other: 14 Total: 104</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1 Sample: 4 Sanctuary at Holy Cross was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the Investigation of Complaint Number IN00086091. Quality review completed 4-25-11 Cathy Emswiller RN	{F 000}			